BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

MARK L. GRAMS, M.D.

Holder of License No. **11869**
For the Practice of Allopathic Medicine
In the State of Arizona.

Board Case No. MD-03-0514A

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

(Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on December 2, 2004. Mark L. Grams, M.D., ("Respondent") appeared before the Board without legal counsel for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following findings of fact, conclusions of law and order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 11869 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-03-0514A after receiving notification of a malpractice settlement involving Respondent's care and treatment of a 46 year-old female patient ("MW").

4. MW presented to the emergency room at John C. Lincoln Hospital on March 21, 1999. MW had a pulse of 112, respiration of 24 and her blood pressure was within the normal range. MW's temperature was not listed in the emergency department report, but the nursing flow sheet lists MW's temperature as 104° at 1840

hours and 102.5° at 1920 hours. Respondent's physical examination of MW established her lungs were clear to auscultation and percussion.

5. Respondent diagnosed MW as suffering from sinusitis, bronchitis, pharyngitis, and sinus pressure in her head. The only diagnostic testing Respondent performed was a rapid strep test. MW's chart indicated an allergy to Vistaril, codeine and penicillin. However, Respondent prescribed Tessalon, Keflex, and Vistaril. Some of the prescriptions intended for MW were written in the name of another patient. Respondent discharged MW with instructions to follow-up with her physician in 48-72 hours or return to the emergency room as needed.

6. MW returned to the emergency room forty-eight hours later and was admitted to the intensive care unit ("ICU") suffering acute respiratory failure secondary to multibular pneumonitis as a result of pneumococcus. MW was hospitalized for an extensive period of time with multiple adverse health conditions requiring continued medical care and treatment. Board Staff's review of Respondent's records revealed two different emergency room notes. The notes do not give a date of dictation, but the typing dates are 21 days apart. During an interview with a Board Medical Consultant Respondent acknowledged the discrepancy, but could not explain it. Respondent also admitted to prescribing the Vistaril in spite of the indicated allergy and that his failure to record MW's temperature with the rest of her vital signs was an error. Respondent could not explain to the Consultant why he did not order a chest x-ray. Respondent also conceded that not admitting MW was not a good decision.

7. Respondent testified at the formal interview that MW was one of the first patients he saw on the night shift when he was working in the emergency department five years ago. Respondent stated there were new nurses on staff he had not worked with before. Respondent testified there were four different names stamped on MW's

chart and he does not believe any one of them was correct. Respondent believes this may have led him to write the prescriptions in the names of other patients. Respondent testified he did prescribe Vistaril, but he does not know how it occurred because he usually keeps the chart in front him when he writes a prescription. Respondent speculated when he wrote the prescription he may have looked at another one of the multiple charts he would have had in front of him. Respondent testified since this incident he has modified what he has done and he checks every patient's name every time he talks to them to make sure he has the right person.

8. As far as the differing dictation dates, Respondent testified he recalls MW's chart was either lost or held back and he was asked for a second dictation with only partial information. Respondent stated he now charts every day and the chart is usually finished before the patient leaves the department. Respondent testified he had no answer for why he did not do a chest x-ray or admit MW right away. Respondent stated if a patient with MW's symptoms presented to him today he would do a more thorough investigation.

9. Respondent testified he was Board eligible by the American College of Emergency Medicine. Respondent was asked to further discuss the wrong name on prescriptions intended for MW. Respondent testified he was not the registration clerk and his culpability or fault was not asking MW for her identification, but there are some federal regulations telling him he should not. Respondent indicated he now usually informally asks the patient to make sure he has the right name. Respondent stated the registration people had his trust when he treated MW, but they no longer did.

10. Respondent was asked if he reviewed the "patient care record, triage assessment" completed by the nursing staff prior to his seeing MW. Respondent testified he had. According to the chart, MW's complaint was vertigo, sore throat, chills

for three days, and back pain. An additional complaint is illegible. MW's allergies are listed as Vistaril, codeine, and penicillin. Her vital signs indicate a fever of 104.4°. The assessment also indicates "respiratory" is not applicable and the GU review notes "right flank pain." Respondent was asked to explain the priority listed as "one."

11. Respondent was asked whether, since his notes do not indicate an evaluation of head, eyes, ears, nose and throat, such an evaluation was not done. Respondent testified he usually does a complete examination on every patient because sometimes they can have abdominal pain from pneumonia and it throws everyone off. Or sometimes they have tooth pain and there is nothing wrong with their teeth, but they have an ear infection. Respondent testified he makes every effort to not cut any corners and he does not know why it was not written down. Respondent also testified his normal practice is to document the complete examination.

12. The Board noted both dictations have a similar problem with mixing history and physical indications. Respondent was asked if this was his normal type of recordkeeping. Respondent indicated it was not and testified he normally keeps the portions of the history, the history of present illness and associated complaints in the history portion of the exam and the physical findings would be strictly physical findings. Respondent testified if he was tired or distracted, or there was something else happening, perhaps his dictation would be disorganized and he would come back to the dictation thinking he was still in the history and put a portion of the examination in the history.

13. Respondent was asked for the criteria he found to support his diagnosis of sinusitis. Respondent testified usually a patient has either a large amount of nasal drainage or pressure over the sinuses. Respondent noted he did not have MW's record before him and could not say what he found to support his diagnosis of MW. The

Board noted the record did not have a history a purulent rhinorrhea, or facial pain, did not indicate an examination of tenderness with percussion of the maxillary or frontal sinuses, did not have documentation of transillumination, and did not have other objective studies, such as imaging studies to support the diagnosis. The Board noted the diagnosis appears from the record to have been made simply on the history of sore throat because the examination does not have any objective look at the pharynx. Respondent testified if the information was not there the record does not support his diagnosis.

14. Respondent was asked if he could support his diagnosis of bronchitis. Respondent testified if MW did not have any diminished breath sounds or wheezing in any one particular area, and she did have a history of chronic pulmonary disease, it would be a good thing to have a chest x-ray, arterial blood gases or an oximeter reading, but he did not recall that they were done on MW. Respondent testified usually, if the patient has otherwise clear lungs and no areas of consolidation, wheezing or breath sounds, and they are coughing a great deal, they are either in the continuum of going from totally healthy to developing some type of pulmonary infection. Respondent also stated bronchitis is usually diagnosed after a person would have other supporting objective evidence to prove or disprove pneumonia. Respondent stated the fact he did not have any x-ray does not really help here, but he had an examination of the lungs that appears to be relatively benign when he saw MW.

15. Respondent was asked about MW's information that she took care of children and some of the children had croup, which she was afraid of catching. Specifically, Respondent was asked what the likely cause of croup is and how it is treated. Respondent stated MW was not having the barking cough that children usually have. Respondent stated in treating a child he uses steroids and bronchodilaters,

medications to control fever, and some type of expectorant. Respondent testified the etiological agent for croup is a viral illness. Respondent was then asked why he gave MW Keflex for a viral illness. Respondent testified he gave MW the Keflex to fight off any type of opportunist bacterial secondary infections that might make themselves more apparent in MW's overall condition.

16. Respondent testified he was concerned about adult pertussis in MW with her having been exposed to children who may or may not have been covered for pertussis. Respondent was asked why, if this was one of his concerns, he would choose Keflex as opposed to one of the macrolide antibiotics. Respondent testified he had not looked up the specific therapy regimens and the specific reasoning behind them and not checking MW for that venue was an error on his part.

17. Respondent was asked why he chose Keflex for MW when his dictation and the triage assessment included a penicillin allergy. Respondent stated different sources have different crossover allergy rates from perhaps 1-1/2% to perhaps 6% or higher and he felt the risk was low for MW. Respondent noted he did not recall whether he asked MW if she had tried Keflex before or not. Respondent also noted his experience with individuals who are placed on the appropriate antibiotic is that at least 70% of them have the pharmacist call and ask for a less expensive medication.

18. Respondent was asked why he gave MW Proventil when his physical examination described clear lungs. Respondent testified he was trying to anticipate MW developing any type of airway edema and help open her airway with that medication. Respondent stated most upper respiratory tract infections and other medical illnesses get worse for two or three days before they start improving and he was trying to anticipate MW developing more wheezing or more trouble breathing, and

one of the things she could try would be the bronchodilator-type medication to help her improve a little bit more quickly.

19. Respondent was asked about the significant charting changes he informed the Board he had instituted since he worked at John C. Lincoln. Specifically, the move from dictation to template notes and Respondent's current setting with computerized documentation. Respondent testified he now has experience with two computerized systems. Respondent was asked if he or the various institutions where he subsequently worked instituted the changes. Respondent testified the changes were made for a number of reasons, including clarity, brevity and maximizing resources and to give a standardized chart for all physicians.

20. Respondent was asked to describe his current working conditions. Respondent testified he works at a hospital in Nogales, Arizona and does no more than fifteen twelve-hour shifts a month. Respondent also stated he works at the Tucson Veterans Hospital. Respondent indicated he had taken fifty-four hours of continuing medical education to date for 2004. Respondent was asked to describe how he has changed how he records patient data. Respondent testified he always puts the patient's name tag from the chart on the patient and he makes sure he has the right name. Respondent stated he always makes sure he has the right patient. Respondent was asked about his approach to working up patients with respiratory distress. Respondent testified he was about 10,000 times more aggressive and definitely gets x-rays on almost all patients that have respiratory complaints. Respondent testified he tends to use small fine nebulizer treatments on everybody and listens very carefully to the patients because he realizes he can have a perfectly lucid appearing patient who can have Alzheimer's disease at a young age. Respondent testified he had learned a great deal from MW and her illness.

21. Respondent testified he remembered giving MW the prescriptions and does not remember her protesting they were in the wrong name. Respondent also stated he has had to deal with the sense of not quite meeting his own expectations as to how he would want to care for a person as ill as MW and he has lost a lot of sleep over it. Respondent also testified if he believes a patient will be returning to the emergency room within a day he suggests admitting the patient to avoid having to put the patient on a respirator. Respondent testified he has learned from MW's case and plans to continue learning.

22. An adequate medical record must be a legible record "containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment." A.R.S. § 32-1401(2). Respondent's medical record for MW does not satisfy this requirement.

23. The standard of care requires a physician to perform a thorough history and physical examination, to obtain appropriate studies based on these examinations, to treat with the correct medications to which the patient is not allergic, and to provide the patient with prescriptions in the proper name that they are able to fill to initiate treatment.

24. Respondent fell below the standard of care because he did not perform a thorough history and physical examination, obtain appropriate studies based on these examinations, treat with the correct medications to which MW was not allergic, and did not provide MW with prescriptions in the proper name that she was able to fill to initiate treatment.

25. MW was harmed because the delay in treatment of infectious process resulted in worsening of the process and the development of severe pneumonia and subsequent hospitalization requiring intensive care services and a prolonged recovery.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the patient or the public;) and 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient.")

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED that:

Respondent is issued a Letter of Reprimand for failure to adequately evaluate febrile illness, prescribing medication to which the patient was allergic, and poor recordkeeping.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board within thirty (30) days after service of this Order and must set forth legally sufficient reasons for granting a rehearing or review. A.R.S. § 41-1092.09, A.A.C. R4-16-102, it. Service of this order is

effective five (5) days after date of mailing. If a motion for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 12th day of January, 2005.

THE ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 13 day of January, 2005 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Certified Mail this 13 day of January, 2005, to:

Mark Grams, M.D.
Address of Record

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